STATE OF ARIZONA – ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ACH VENDOR AUTHORIZATION

Attn: AHCCCS FINANCE- MD 5400, P.O. Box 25399, Phoenix, AZ 85002

Transaction Type – Check the applicable transaction(s) and complete the sections indicated.

SECTION 1

Please complete Sections 2 and 3 below; your financial institution *must* complete Section 4 prior to returning the form to AHCCCSA.

New ACH Setup _____ **Change Account Type**_____ **Change Account Number**_____ **Change Financial Institution**_____

If you are requesting a *Cancellation* , please check the box below and complete Section 2, 3, and 5

Cancellation Request _____

SECTION 2

PAYEE INDENTIFICATION

1. Federal Employer's Identification Number (EIN) I__I__I - I__I__I__I__I__I__I__I__I

Or Social Security Number (SSN) I__I__I__I - I__I__I - I__I__I__I__I

Disclosure of your social security number is voluntary pursuant to 42 U.S.C. 405(c)(2)(C).* The State of Arizona will use your SSN or EIN to file required information returns with the Internal Revenue Service.

AHCCCS Provider Number and Locator Code:_____**This must be complete or request may be denied.**

2._____ **3.** (__I__I__)-I__I__I__I-I__I__I__I__I

Payee's Name (Provider) Business Phone (Area code and number)

4._____ **5.** _____ _____ I__I__I__I__I__I__I-I__I__I__I__I

Address City State Zip Code

SECTION 3

AUTHORIZATION FOR SETUP, CHANGES, OR CANCELLATION

6. I authorize the Arizona Health Care Cost Containment System Administration (AHCCCSA) to process payments owed to me via Automated Clearing House (ACH) deposits. AHCCCSA shall deposit the ACH payments in the financial institution and account designated below.

*** I recognize that if I fail to provide complete and accurate information** on this authorization form, the processing of the form may be delayed or made impossible, or my electronic payments may be erroneously made.

I authorize AHCCCSA to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize AHCCCSA to withhold payment owed to me by

I certify that I have read and agree to comply with AHCCCSA' rules governing payments and electronic transfers as they exist on the date of my signature on this form or as subsequently adopted, amended, or repealed. I consent to, and agree to, comply wit

I authorize AHCCCSA to stop making electronic transfers to my account without advance notice.

I certify that I am authorized to contract for the entity receiving deposits, pursuant to this agreement, and that all information provided is accurate.

The financial institution can process CTX payments/transactions along with addendum information. Yes _____ No_____

7.Signature (Required)	**8. Title:**	**9. Date**

SECTION 4

FINANCIAL INSTITUTION (Must be completed by financial institution representative.)

10. Bank Name:_____

11. Bank Address:_____ **12.** City:_____ State:_____ Zip Code: I__I__I__I__I__I-I__I__I__I__I

13. Routing transit number: I__I__I__I__I-I__I__I__I__I-I__I **14**. Customer account number: I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I

15. Type of account: **Checking** _____ **Savings** _____

16. _____ **17**. _____ **18.** (__I__I__)-I__I__I__I-I__I__I__I__I

Financial institution representative name (Please print): Title: Phone (Area code and number):

_____ _____

19. Signature (Required) **20**. Date:

SECTION 5

CANCELLATION

21. Reason: **22.** Date:

SECTION 6

AHCCCSA USE ONLY

23. Provider information verified by:_____ Does Provider have aged invoice balance? Yes_____ Amount $_____ No_____

24. Provider ACH Approved by:_____ Effective begin date:_____

25. Comments:_____

COMPLETED BY_____ **DATED**_____